12.a. Prescribed Drugs.

Prescribed drugs are limited as follows:

A. To qualify for payment the original prescription must be presented within 10 days from the date prescribed.

B. Each eligible recipient is entitled to a basic number of prescriptions each month.*

C. As many as five refills may be authorized by the prescriber, but the total number authorized must be dispensed within six months of the date of the original prescription subject to State and Federal laws for controlled substance drugs.

D. The State will reimburse only for the drugs of pharmaceutical manufacturers who have entered into and have in effect a rebate agreement in compliance with Section 1927 of the Social Security Act, unless the exceptions in Section 1902(a)(54), 1927(a)(3) or 1927(d) apply. The State permits coverage of participating manufacturers' drugs, even though it may be using a formulary or other restrictions. The State will cover new drugs of participating manufacturers (except excluded/restricted drugs) for six months after Food and Drug Administration approval and upon notification by the manufacturer of a new drug. Any prior authorization program instituted after July 1, 1991 will provide for a 24-hour turnaround from receipt of the request for prior authorization. The prior authorization program also provides for at least a 72-hour supply of durgs in emergency situations.

E. No payment will be made for drugs in hospitals, nursing facilities and other institutions where those drugs are included in the reimbursement formula and vendor payment to the institution.

* Durational, dollar, and quantity limits are waived for recipients of EPSDT services. Services allowable under Medicaid laws and regulations may be covered when medically necessary for these recipients.

12.a. Prescribed Drugs (Continued).

F. Expanded pharmacy benefits under EPSDT will end on the last day of the month in which the individual has his or her 21st birthday.

12.b. Dentures.

Not provided.

12.c. Prosthetic Devices

Hearing Aids

In accordance with the specifications, limitations and other conditions established by the single state agency, payment will be made for appropriate hearing aids, evaluations, and follow-up visits when hearing loss and recommendations of need for such device have been determined by a physician licensed to practice medicine or osteopathy in the state where and when the service is performed. Hearing aid services must be furnished by providers approved for participation in the Texas Medical Assistance Program. Providers must meet applicable Federal and State licensing laws and rules where, when and for the service(s) provided. Hearing evaluations performed by fitters and dispensers are not reimbursable; however, payment will be made for the hearing aid. If a fitter or dispenser performs a hearing evaluation on a recipient the recipient shall not be billed for the hearing evaluation. In addition, audiologists must be currently certified by the American Speech-Language Hearing Associa-tion or meet the Association equivalency requirements. Reimbursements are limited to one hearing aid per recipient every six years (72 months) from the dispensing month of the present instrument. Hearing aid benefits do not extend to replacement, repair or other supplies or to services covered by warranties and/or protection plans for hearing aids or to any hearing aid services or supplies available through other programs or agencies.

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DATE REC'D 09-13-96
DATE APPV'D 10-11-96
DATE EFF 09-03-96
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SUPERSEDES: TN -

12.C. Prosthetic Devices (continued)

In-home Services for Total Parenteral Hyperalimentation.

(a) Subject to the specifications, conditions, limitations, and requirements established by the single state agency, in-home total parenteral hyperalimentation services are available to eligible recipients who require long-term support because of extensive bowel resection and/or severe advanced bowel disease in which the bowel cannot support nutrition. Covered services must be reasonable, medically necessary, and prescribed by the recipient's physician (M.D. or D.O.). The physician must be licensed in the state in which the physician practices.

(b) The single state agency or its designee must prior authorize the services. Prior authorization requests must include all pertinent medical records as required by the single state agency or its designee to justify the medical necessity of long-term total parenteral hyperalimentation. Prior authorization is a mandatory requirement for payment. The single state agency or its designee reimburses each provider on a monthly basis. Reimbursement is based on one-twelfth of the maximum yearly fee of $45,000.00 established by the single state agency.

(c) Covered services include, but are not necessarily limited to:

(1) Parenteral hyperalimentation solutions and additives as ordered by the recipient's physician.

(2) Supplies and equipment including refrigeration, if necessary, that are required for the administration of prescribed solutions and additives.

(3) Education of the recipient and/or appropriate family members/support persons regarding the in-home administration of total parenteral hyperalimentation before administration initially begins. Education must include the use and maintenance of required supplies and equipment.

(4) Visits by a registered nurse appropriately trained in the administration of hyperalimentation. The nurse must visit the recipient at least once per month to monitor the recipient's status and to provide ongoing education to the recipient and/or family members/support persons regarding the administration of hyperalimentation.

(5) Enteral supplies and equipment, if medically necessary, in conjunction with total parenteral hyperalimentation.

(d) The services identified in subsection (c) are components of a service package and are not separately billable.

(e) Providers of in-home total parenteral hyperalimentation must:

(1) Comply with all applicable federal, state, and local laws and regulations;

(2) Be enrolled in and participating in Medicare as a supplier of in-home total parenteral hyperalimentation;

(3) Be enrolled and approved for participation in the Texas Medical Assistance Program;

(4) Sign a written provider agreement with the single state agency or its designee. By signing the agreement, the provider agrees to comply with the terms of the agreement and all requirements of the Texas Medical Assistance Program including regulations, rules, handbooks, standards, and guidelines published by the single state agency or its designee; and

(5) Bill for covered services in the manner and format prescribed by the single state agency or its designee.

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Supersedes None - New Page

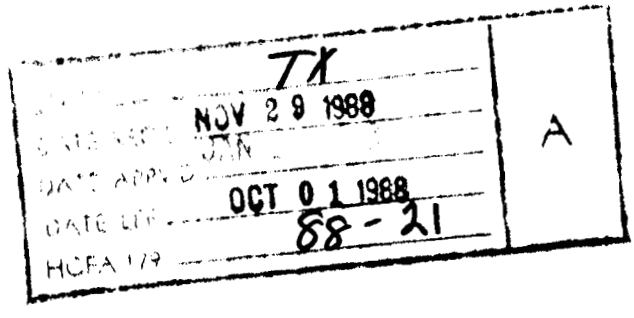
12.d. Eyeglasses.

The vendor program for eyeglasses is limited as follows:

A. Payment is not authorized for eyeglasses with little or no chance for correction of refraction errors.

B. Payments are limited to basic serviceable types of lens and style of frames which meet specifications established by the single state agency.

Benefits for eyeglasses are available not more often than one time during a two year (24 consecutive months) period. Exceptions to this limitation will be based on reasonable positive indications of the recipient's need. Repair or replacement of lost or destroyed nonprosthetic eyewear is not a benefit and is not reimbursable by the program. Eyeglasses services provided in skilled or intermediate care facilities are reimbursable by the program if the recipient's attending physician has ordered the service(s) and the order is included in the recipient's medical record in the nursing facility.



13.a. Diagnostic Services

Diagnostic Services for Persons with a potential of Mental Retardation

Not Provided

STATE	Texas
DATE [illegible]	6-16-98
DATE APP'D	9-10-98
DATE EFF	5-1-98
TN/PA #	98-08

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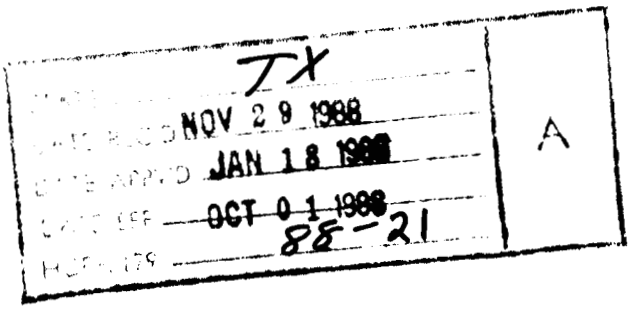
SUPERSEDES: TN - 89-32

13.b. Screening Services.

Not Provided.



13.c. Preventive Services.

Not provided.